Washington State Department of Early Learning

HEALTH SERVICE REQUEST

Facility name		License ID #	10 digit facility phone number
Facility address	City	Zip code	County
Mailing address		City	Zip code
Contact person's name and title			10 digit telephone number – extension if any
Previous name(s) of this center			☐ Copy of floor plan attached
Previous address			
Name(s) of other licensed centers previous at this location			
Directions to facility			

Child Care

☐ Child care ☐ School age centers ☐ Family home provider	☐ Summer only ☐ Seasonal ☐ Before/after care ☐ School year only	License or application expiration date	Hours of operation A.M. - P.M.
		Days of operation	

Type of Health Service Requested

☐ TA – w/Licensor (On Site) ☐ TA – w/o Licensor (On Site) ☐ Feasibility (On Site)
☐ Plan Review (Off Site) ☐ Staffing/Training – (see comments below) ☐ TA – Complaint (On Site)
☐ TA – Complaint (Staffing)

Capacity

Current licensed capacity	Requested number of children	Ages through years	Number of infants
Licensor	Region	10 digit telephone number	Date completed
Licensor's comments:			
Health Specialist's name	Service Area	10 digit telephone number	Date completed
Health Specialist's comments: ☐ Approved ☐ Disapproved			